No. 14627

In the United States Court of Appeals for the Ninth Circuit

UNITED STATES OF AMERICA,
Appellant,

vs.

AMOS R. MORIN,
Appellee.

APPELLANT'S BRIEF

On Appeal from the United States District Court
for the District of Oregon

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On Appeal from the United States District Court for the District of Oregon

JURISDICTION

Appellee brought action for compensation for damages claimed sustained by the plaintiff as a result of alleged negligent medical treatment by the U. S. Public Health Service and its agents. Appellee demanded the reasonable value of services of physicians and surgeons, hospital expense, medicines and loss of wages. Recovery was sought under the Federal Tort Claims Act.

Appellee filed this complaint in the United States District Court for the District of Oregon November 17, 1953 (Tr. 3). Appellant answered July 1, 1954 (Tr. 7). A pre-

trial order was prepared, submitted and approved by the Court, and the case proceeded to trial before the Honorable Claude McColloch, the United States District Judge for the District of Oregon, July 21, 1954. On August 4, 1954 the Court entered a Memorandum of Opinion (Tr. 22). August 10, 1954 the Court made and entered its findings of fact and conclusions of law (Tr. 23 to 27). Judgment was made and entered in favor of Appellee on August 26, 1954 (Tr. 27 and 28). Notice of appeal was filed with the Clerk of the United States District Court for the District of Oregon October 25, 1954 (Tr. 29).

Jurisdiction over this action existed in the District Court under 42 USC Sec. 249, 28 Stat. 696, as amended, and 28 USC Sec. 1346(b), 62 Stat. 933, as amended.

STATEMENT OF THE CASE

Plaintiff Morin was at the times herein concerned employed by the Corps of Engineers, United States Army, as a seaman (third mate) aboard a public vessel used primarily as a river dredge. On June 10, 1952, he was on annual leave and engaged in painting his residence, on a ladder. About 12:30 P. M. the ladder slipped and fell with plaintiff to the ground, and the plaintiff landed in a sitting position. In the fall, plaintiff suffered a severe compression fracture of a lumbar vertebra, and a comminuted compound fracture of his lower left leg. Plaintiff, immobilized by the fall,

called his two teen-age sons for assistance, and they at once procured medical assistance from a physician who lived nearby. This physician, Dr. Doane, noted plaintiff's condition and distress and administered morphine before removal of the plaintiff by ambulance. The ambulance driver was directed by the plaintiff to go to Physicians & Surgeons Hospital, which the plaintiff knew had a contract with the U. S. Public Health Service from which Service the plaintiff was entitled to medical care as a seaman. Plaintiff also carried Blue Cross Insurance, and was a navy veteran.

Plaintiff was admitted to the emergency surgery of that hospital shortly after 1:00 P. M. and given initial examination, antiseptic cleansing, antibiotics, and morphine for pain. He was X-rayed, and the leg splinted and immobilized by heavy bandaging. This initial care was by a resident physician at the hospital, Dr. C. O. Schneider, who promptly contacted by telephone Dr. Lee A. Craig, Jr., a staff physician of the U. S. Public Health Service in Portland, Oregon, who advised him the case would be directed to Dr. John B. Leonard, a general surgeon in Portland, Oregon, and part-time contract consultant with the U. S. Public Health Service. Dr. Leonard was promptly notified of this employment and of the patient's condition.

Because of plaintiff's pain and distress and general injuries and condition, Dr. Schneider was concerned about the danger of shock to the patient, who had symptoms of

potential shock. In the judgment of the attending physicians, rest and improvement of the plaintiff's general condition were of greater importance than immediate reduction of the leg fractures. By consultation of the attending physicians, including Dr. Leonard, Dr. Craig, and Dr. A. T. Morrison, who was the physician in charge of the U. S. Public Health Service in Portland, on the day following the accident, it was determined that the patient should on the morning of June 12th, the next day, be taken to the U. S. Marine Hospital in Seattle, Washington by ambulance for subsequent surgical care and hospitalization. This was done and the patient after about a four hour ride in a well-equipped late model ambulance, was delivered to the Seattle hospital about noon, and promptly taken to surgery. His leg bones were set, a leg cast and a body cast applied. The lacerations to his shin, being about an inch and one and one-half inches in length, respectively, were sutured at that time, and about 10 days thereafter the leg cast was windowed, and the lacerations appeared completely healed. There was, however, crepitation in the bones, and because they had not knit, open reduction of the fractures was determined upon. On July 5, 1952, for that purpose, a sliding bone graft was surgically performed and an Eggers plate applied to the shin bone. Thereafter, the incision healed slowly. Plaintiff was discontented in Seattle, although no complaint is made about the excellence of his care there, and left the hospital August 17, 1952, against advice, and returned in the family

automobile, operated by his wife, to Portland and sought treatment by his family physician, Dr. Thorup, who associated Dr. Cherry as orthopedic consultant. Plaintiff, August 24 to 28, 1952 was hospitalized in the Providence Hospital in Portland, and Dr. Cherry put the patient under an anesthetic and by asserting pressure to the side of the fracture, tried to straighten a small angulation in the tibia. The leg was then casted and pressure applied to the cast to effect further bone straightening.

Plaintiff November 5, 1952, returned to the U. S. Public Health Service in Portland as an out-patient. On December 8, 1952, plaintiff returned to his job aboard the dredge. At this time the bone had knit and was solid, and the incision which had previously had some drainage completely healed. Plaintiff was given light tasks and continued to work until January 22, 1953, when he returned to the care of Dr. Cherry, and was hospitalized in Providence Hospital in Portland, January 24, 1953, for the removal of a piece of dead bone—a sequestrum—at which time Dr. Cherry stated he also removed a small amount of pus, and one week later operated and removed the Eggers plate and screws. His condition was then appraised to be osteomyelitis and thereafter he had drainage in the affected area of the left leg, which progressively increased. April 25, 1953, he was hospitalized in the U. S. Veterans Hospital in Portland, Oregon. The osteomyelitis was there given effective treatment and a series of skin grafts accomplished. Plaintiff was

discharged from the Veterans Hospital in March, 1954, the records indicating complete cure. The last period of hospitalization was intermittent, broken by furloughs.

Plaintiff's claim for damages, as summarized in the pretrial order was: $65,000.00, general damages; loss of wages, $6,388.32; and medical and surgical expenses of $523.75. The trial judge awarded plaintiff $45,000.00 general damages; $4,711 special damages, and his costs incurred in the action.

Plaintiff claims that the above damages were the result of negligent treatment accorded him by the agents and staff of the U. S. Public Health Service from the time of his entry at the Physicians & Surgeons Hospital and his removal to Seattle, a period of about 48 hours.

STATEMENT OF POINTS RELIED UPON

The points relied upon by the United States (T.R. 399-400) are:

1. The evidence in the case fails to establish that there was any deficiency in the treatment accorded appellee in the Physicians & Surgeons Hospital at Portland, Oregon.

2. If there was a deficiency in the treatment accorded appellee as charged, the evidence fails to establish that it was the direct and proximate cause of appellee's osteomyelitis, or the residual disability, pain and suffering resulting therefrom.

3. The Court erred in finding that appellant, in treating appellee, did so in a negligent, careless manner proximately causing injuries to appellee, by failing to render appellee immediate, adequate and proper medical and surgical treatment, cleanse debridement and closure of wounds at the site of the fracture of the left tibia.

4. The Court erred in finding that appellant, in treating appellee, failed to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon, and like communities in the treatment of the comminuted compound fracture of the left tibia.

5. The Court erred in rendering a verdict in favor of appellee and against appellant because there was no substantial evidence to support said verdict.

6. The District Court erred in making and entering its Judgment, dated August 26, 1954, herein appealed from, by ordering, adjudging and decreeing judgment in favor of appellee herein and against the United States of America, appellant herein, for the reasons set forth in specification of errors Nos. 1 to 5, inclusive, herein designated.

7. That the verdict as rendered by the District Court was excessive.

8. The District Court erred in finding that appellee would be required to undergo further operations.

ARGUMENTS IN SUPPORT OF POINTS ONE AND THREE OF APPELLANT'S ASSIGNMENT OF ERRORS

The basis of support of these assignments of error are primarily factual in nature. Perhaps the answer lies primarily in the treatment afforded to appellee by Dr. Constantine Otto Schneider, the resident physician of the Physicians & Surgeons Hospital. Dr. Schneider had completed his internship in one of the better hospitals in the west, the Anckor Hospital in St. Paul, Minnesota. It was a hospital perhaps twice as large as any general hospital in the City of Portland, Oregon. To it were sent most of the emergency cases arising in the city of St. Paul, Minnesota.

We contend that the emergency care given to appellee by Dr. Schneider was correct and adequate in every respect. This care embraced the cleaning of the wound, dressing it so that it would not become contaminated, immobilizing it by splinting and bandaging, the taking of the necessary X-rays and putting him to bed for rest as quickly as possible. To view this case clearly, we should try to view it through the eyes of Dr. Schneider as the appellee was brought into the emergency surgery. First there is the history of the case as given to the nurse and to Dr. Schneider that the appellee had fallen approximately 20 feet (Pltfs. Exh. No. 1, pg 19) from the ladder from which he was painting his house. He landed on his back at the edge of a cement sidewalk. When

admitted to emergency surgery, although sedated, appellee's pain was very severe, with complaints directed primarily to his back. Dr. Schneider's concern is concisely stated when he said:

> "I think my primary consideration in this case was to relieve his pain, because the patient was extremely disturbed and complaining of a great deal (Tr-107) of pain in his back, and alleviation of pain of course controls shock."

Also:

> "Of course my primary care was shock, because death can result from shock. My secondary consideration was the possibility of a back fracture which might result in disection of the cord, and, therefore a complete paralysis." (Tr-108)

Further, with reference to the first examination by Dr. Schneider, you have this testimony:

> A: "As soon as we had him on the table and had given the medication I described and had done the blood pressure, pulse and respiration and had checked his wound superficially, I tried to determine the extent of his injuries.
>
> "On examination we found a couple of small lacerations and a large abrasion in the left leg with palpable crepitus. As I remember, the bone was visible through the wound or wounds.
>
> "We examined him somewhat in reference to his back, but his pain was so severe that we did not want to manipulate it too much at that time." (Tr-79)

In several places in the transcript Dr. Schneider testified about the cleansing of this wound. A part of his testimony in this regard is as follows:

> Q: "Then you testified as to the detergent and mild antiseptic used. In what area or over what area did you use that antiseptic and detergent?
>
> A: "I used that around the area immediately surrounding the open wound, and then attempted to wash out any bacteria or contamination that might be present. (Tr-111). . . .
>
> Q: "You first cleaned the abrasion?
>
> A: "Yes. Then we poured some of the saline solution, (Tr-111) as I remember it, all over the wound in an attempt to clean it; that is, to wash out any dirt or bacteria that might be present. After it was thoroughly cleaned, then we applied a large compression dressing over it.
>
> Q: "Counsel asked you something about excising the wound or about debridement.
>
> A: "By strict definition, debridement involves removing of foreign matter and excision of all the tissues immediately surrounding the wound, after you irrigate the wound and wash the dirt out of it.
>
> Q: "Was there any such tissue in this case, as far as you recall, that needed to be excised?
>
> A: "To the best of my recollection, no, there wasn't. I couldn't find any. The wounds were small, and there didn't appear to be any." (Tr-112)

Following the cleansing of the wound, Dr. Schneider proceeded to dress it which process he described as follows:

> "Compression dressing consists of dry, sterile dressing applied directly over the wound; then the entire leg is wrapped in what we call compression cotton, which is a heavy, bulky cotton, you might say; the compression cotton is thoroughly wrapped on and then Ace bandages applied to maintain compression of the leg, to prevent bleeding and to prevent swelling." (Tr-83)

After X-rays were taken of the appellee's leg and back he was then put to bed, his leg elevated on pillows to help control the swelling and bleeding and the back was put in hyperextension, that is, it was elevated. (Tr-113) Dr. Schneider testified that generally patients with compression fractures of the spine are placed in hyperextension to help prevent any possibility of bad effects to the spine.

Plaintiff's Exhibit No. 1, page 8, contains Dr. Schneider's written orders for care of Mr. Morin. The first directive was for penicillin to prevent infection. The other orders and their purpose is stated by Dr. Schneider as follows:

> "The second order is for morphine sulphate, for pain, given to help allay shock. In this particular case I ordered a complete blood count and, to avoid shock, I ordered that they have blood available. Sedation was indicated and I ordered Sedamyl. I ordered Deprapanex, 4 cc's, intermuscular. That is a gentle bowel stimulant, given to allay ileus. I ordered general diet as tolerated but none until Dr. Leonard gives his OK." (Tr-88)

Appellee's medical expert said as to these orders, "Those are standard, excellent practices." (Tr-220)

These orders were all carried out except that shock being avoided there was no blood transfusion necessary. Mr. Morin did develop ileus as was expected. He remained in Physicians & Surgeons Hospital until 8 o'clock A.M., June 12, 1952, when he was transported to Seattle via ambulance.

Dr. John E. Leonard, general surgeon and consultant in charge of this case, testified as follows:

> "Naturally my memory has been refreshed by Dr. Schneider talking to me and telling me he called me, and if he had not called me he would not have said so.
>
> * * * * *
>
> A: "It is my own personal opinion that the treatment of this man at that time was very adequate and excellent.
>
> "I would like to go just a step further and say that if I ever have a compound fracture and a broken back at the same time, I would not want any different treatment than was accorded in this case to this man.
>
> "Of course, I understand fractures sometimes are treated in different ways.
>
> Q: "Yes, fractures sometimes are treated in different ways, and there is a respectable segment of the medical profession who feel the wound must be closed within six to eight hours. Do you subscribe entirely to those views?

A: "No, I don't. I think every case is an individual case and you must observe it and treat it accordingly. You must prepare yourself for certain things that might happen.

"I think anybody who has had an injury like this (Tr-294) man sustained has had about all he should have in one day. I never have believed in this immediate setting of fractures.

"However, that is my own personal opinion and I have seen lots of fractures, and it is my own personal opinion that would certainly add to his shock.

"A man might be holding his own and be in pretty good shape, in better shape than you would really believe, but I have always felt—and again this is my own opinion over several years—that he is standing up pretty well under the present load and if you add a little more burden to it you could push him into shock, shock of different degrees.

"Also I certainly do not subscribe to the reasoning that a fracture should be set immediately. I do not think that is necessary. That again is my own personal opinion." (Tr-295)

A doctor must exercise the highest order of discretion in determining what is best for his patient. To have taken this man to surgery would have necessitated the administration of an anaesthetic. General anesthesia, textbooks say, is or can be the cause of shock (Tr-115). Dr. Berg, orthopedic specialist, said: "Well, of course you don't like

to add further shock to him. Anaesthesia is a shock too." (Tr-360)

Although Dr. Leonard has no recollection of discussing this case with Dr. Schneider on June 10, 1952, there is this circumstance which would indicate that he was consulted about the man's condition. Dr. Schneider's order sheet (Plaintiff's Exhibit No. 1, page 8), says:

> "General Diet as Tolerated—but none until Dr. Leonard gives OK."

The bedside notes (Plaintiff's Exhibit No. 1, page 10), show that on June 10, 1952, at 5:45 P.M. the patient "refused diet". Bedside notes, page 10a, show on the morning of June 11, prior to the time that Dr. Leonard visited the patient, an entry "Light diet. Fed—ate fair." From this we must assume that Dr. Schneider's instruction had been complied with and that Dr. Leonard did okey the diet of appellee. It must also be assumed then that he had full knowledge of the case to the extent that Dr. Schneider was able to inform him.

The Court having found appellant negligent in failing to render to appellee immediate, adequate and proper medical and surgical treatment; cleanse debridement and closure of the wounds at the site of said comminuted compound fracture of the left tibia, proximately causing his later suffering, infection of the bone of the tibia, etc., we must then analyze appellee's testimony and determine where they take

issue with us in the treatment that we rendered this patient. These accusations of negligence come entirely from the testimony of Dr. Howard L. Cherry, plaintiff's physician. Pertinent portions of his testimony are set forth as follows:

> "I would say if there had been only one gross error in his treatment, I would say the lack of adequate, immediate care, nothing else, is of enough significance to be of extreme importance to me. . . ." (Tr-245)

And again:

> "Let me say this: there are a hundred ways of treating a fracture; but if it is a compound fracture, it should start with very adequate cleaning of the debris and closing the wound, if possible, and from there on in they can be treated in many ways."

Again Dr. Cherry stated:

> "The proper treatment, in my opinion—and I believe it is shared now universally—is that this wound (Tr.-240) should be very carefully examined, carefully cleaned, to its depth, reduced if possible, and the wound closed. If there is any foreign material anywhere, it should be removed. If there is devitalized tissue anywhere, it should be removed.
>
> "The time element is of extreme importance. We figure that what we call the golden time in the treatment of fractures, compound fractures, is from six to eight hours. . . ." (Tr-241)

This testimony of Dr. Cherry should be considered in the light of one of plaintiff's exhibits, being Plaintiff's Ex-

hibit No. 13 set forth on page 375 of the transcript, entitled "Campbell's Operative Orthopedics", which is Dr. Cherry's own medical textbook. Because of the importance of some of the language contained in this book, following are two paragraphs appearing at Tr-375 and Tr-376.

> ". . . The object of emergency treatment is the conversion of a contaminated wound to a clean wound . . . and the conversion of a potentially infected open fracture to a healed, closed one. Treatment of the fractured bone is secondary to the prevention of infection.
>
> The first consideration is the patient's general condition. Emergency measures . . . are frequently necessary to combat pain, hemorrhage and shock; thereafter, attention is directed to the local condition. From the time of injury until the patient is ready for the local preparation, the wound should be protected by a dressing and the extremity splinted." (Tr-376)

In the same textbook (Tr-377) the various types of wounds are classified into three types. Dr. John E. Leonard, in testifying for appellant, classified the lacerated wounds as being Type 1 (Tr-300), whereas Dr. Cherry classified the wounds as Type 2. It is significant, however, that Dr. Cherry in answer to a question "Could it be that your opinion might be wrong?", replied, "Yes, I have heard quite a little discussion about this." (Tr-271) This same medical text (Tr-379) states as to Type 1 that a preliminary cleansing is usually sufficient.

The above quoted paragraphs from the medical textbook referred to by Dr. Cherry are undoubtedly the most widely accepted method of treatment of compound fractures. It is the contention of appellant that Mr. Morin was treated in exactly the fashion recommended in this medical text. There is only one man who has personal knowledge of the cleaning of this wound. He has testified as plaintiff's witness that the wound and the abrased area around the wound were thoroughly cleaned. There is no competent evidence that can in any way refute this testimony.

Medicine is not an exact science and it calls for the exercising of discretion of the very highest order. Physicians do not insure cure. In this particular case it was the determination of those doctors having knowledge of the condition of Mr. Morin that it would be to his best interest to put him to bed for rest after first cleansing the wound and making it a clean wound rather than a potentially contaminated one. Appellee must of course destroy Dr. Schneider's testimony pertaining to the cleansing of the wound. It is no doubt a fair statement to say that Dr. Cherry is not disinterested and his testimony as an attending doctor and his opinions as a specialist in many respects have been shown to be colored. Some of his own practices which he carried out in his treatment of this patient were criticized and under attack and he felt called upon to explain them to a certain extent. In other places in his testimony he has definitely shown himself to be biased and prejudiced. Later on in this

brief it will be shown that his testimony in many respects was greatly exaggerated. Talking about Dr. Schneider, who claims the wound was thoroughly cleaned, he says in part:

> "I don't know your Dr. Schneider. I don't know him when I see him at all, but anyone who had had adequate training and had seen compound (Tr-263) fractures should know that you don't treat them *by wiping something over them and putting a dressing on them* . . ." (Emphasis Added) (Tr-264)

Again, speaking about Dr. Schneider and the emergency treatment rendered by him, Dr. Cherry said:

> "I would say he gouged out the wound" (Tr-267)

Regarding Mr. Morin going to USPHS at Seattle, he said:

> ". . . I think it was very much to his benefit to go up there and get a doctor, yes, rather than just lie here. . . ." (Tr-275)

It seems very obvious that Dr. Cherry found it necessary to take issue with Dr. Schneider on the cleansing of Mr. Morin's lacerated leg. If he were to admit that the emergency treatment was adequate then appellee's case is lost, for Dr. Cherry admits that after adequately cleaning a wound:

> ". . . There are a hundred ways of treating a fracture; but if it is a compound fracture, it should start

> with very adequate cleaning of the debris and closing of the wound, if possible, and from there on in they can be treated in many ways." (Tr-269)

Appellant does not disagree with the aforesaid statement or with the quotations aforesaid of the medical text. What appellant tried to do was to cleanse the wound and convert it from a potentially infected wound to a closed, clean one. Until Mr. Morin's condition became stabilized so that the fracture could be reduced, the wound was protected with sterile dressing. Dr. Schneider's appraisal was that the patient at the time was in impending or incipient shock (Tr-114). This was confirmed by Dr. Cherry several times. In illustration, Dr. Cherry said, "This man, as illustrated by the chart, was not himself. There was danger of going into shock." (Tr-262). Again, he said, " I would say this, that with these injuries, these potentials, he very well might have gone into shock. . ." (Tr-266). With anaesthesia, itself a shock, it would surely be discretionary with the attending doctor to determine if he wished to subject his patient to further shock by administering anaesthesia and reducing the fracture, or, in the alternative, to give him bed rest and await stabilization of his condition. If it was discretionary, as aforesaid, to delay surgery, and, instead, treat his general condition, then there is left but one issue—was Dr. Schneider negligent in the cleaning, splinting and bandaging of the wound of Mr. Morin's lower left leg?

The finding of the court that appellant was negligent and careless in failing to render to appellee immediate and adequate, proper medical and surgical treatment; cleanse debridement and closure of the wounds at the site of said comminuted compound fracture of the left fibia, appears clearly erroneous in that it is unsupported by any substantial evidence whatsoever and is contrary to the great weight of the evidence. *Sbicca-Del Mac. Inc., v. Milius Shoe Co.* (CCA 9), 145 F 2d 389, 395. Appellee's evidence condemning the emergency treatment and the treatment rendered at the Physicians and Surgeons Hospital at Portland, Oregon, was not such evidence as a reasonable mind would accept as adequate to support a conclusion of the court of plaintiff's negligence as heretofore set forth. *Edison Co. v. Labor Board,* 305 U.S. 197, 227. The type and the weight of the evidence submitted on behalf of appellee in support of the finding aforesaid is such that the reviewing court herein should be left with a definite and firm conviction that the lower court committed a mistake in finding as it did and that said finding was clearly erroneous. *U. S. v. U. S. Gypsum Co.,* 333 U.S. 364, reh. den. 333 U.S. 869.

In support of the proposition that an attending doctor will not be liable for an error in judgment see *Hills vs. Shaw,* 69 Ore. 460, 467, where the Court stated in part:

> "The substance of the doctrine taught by these cases that if a regularly licensed physician with reasonable diligence employs the skill with which he is

possessed in treating a surgical case, he is not liable for an error in judgment, and that the mere fact that an untoward result ensues is not in any sense evidence of negligence. There are so many elements combating the surgeon in his efforts to restore a patient to bodily soundness that he can do no more than exercise his skill and judgment to accomplish the desired result. . ."

In *Grace Bros., Inc.* vs. *Commissioner of Internal Revenue Commission,* 173 F. 2nd 170 (9 CCA) under Federal Rule that findings of fact shall not be set aside unless clearly erroneous, findings are to be given the effect which they formerly had in equity.

In an equity case decided by the Supreme Court of Oregon entitled *In Re De Lin's Estate, Richards, et al* vs. *De Lin, et al,* 135 Ore. 8, where the Court had occasion to evaluate testimony of an expert medical witness based on hypothetical questions as compared to positive testimony of the physician who treated testatrix. The Court said at pages 13 and 14:

"The evidence on behalf of contestants is contradictory of the evidence adduced by proponents. After carefully weighing all of the evidence, we are persuaded that the weight of the evidence is decidedly in favor of the proponents. We cannot give to expert testimony based on hypothetical questions the same weight we do to the direct and positive testimony of the doctor who treated testate. . . ."

In the case of *Equitable Life Assurance Society of the U. S.* vs. *Ireland,* 123 F. 2nd 462, 465 (CCA 9), this Court said,

> ". . . The evidenciary value of the opinion (expert medical witness) is so inconsiderable as to render it worthless for all practical purposes; and the fact that it was given orally does not require that a viewing Court to accept it as adding to the weight of the finding below."

Throughout this case we have seriously and earnestly maintained that the initial emergency care given by Dr. Schneider embraced a cleaning of the wound which Dr. Schneider in his best judgment was, he considered, thorough and complete. We further maintain that while Dr. Cherry violently disputes this statement and maintains there was no cleaning whatsoever of the wound, his disagreement has no basis whatsoever in fact. Since there was no contradiction worthy of consideration in this case regarding Dr. Schneider's treatment, nor was Dr. Schneider impeached, it would appear the statement of this Court in the case of Grace Bros. vs. Commissioner of Internal Revenue, Supra, is in point:

> "It is axiomatic that uncontradicted testimony must be followed. Citing cases . . ."

The appellee had the obligation to establish his case by a preponderance of the evidence. We submit the evidence produced does not meet this requirement.

ARGUMENT IN SUPPORT OF POINTS TWO AND FIVE OF ITS ASSIGNMENTS OF ERROR

The undisputed testimony in this case is that the lacerations sustained in this accident were completely healed by July 5, 1952 (Tr-318); that the wound some ten or eleven days thereafter was still clean (Tr-328), and there being no evidence of infection in this wound and in order to hold the bones of the left tibia in apposition, Dr. Paul Walker did a sliding bone graft and put in an Egger's plate. The setting of the bone on June 12, 1952, by manipulation had not held up in that the bones had not stayed in an end to end position and had become displaced. (Tr-328) Dr. Paul Walker, the chief surgical and medical director of the United States Marine Hospital in Seattle, Washington, personally performed this operation. During the operation Dr. Walker took fragments of bone and tissue and gave them to the chief pathologist at the hospital, who was also the associate professor of pathology at the University of Washington Medical School, who microscopically examined these particles of bone and tissue and reported that there was no evidence of osteomyelitis in the tissue submitted. (Tr-330) There was no significant temperature rise in this man throughout his hospital stay after the first four or five days from the first operation and about four days from the second operation. (Tr-330) The significance of the fact of there being no temperature rise is that if there is no upward trend of the temperature then there is no in-

fection in any degree whatsoever. (Tr-330) See also Dr. Warren C. Hunter's supporting testimony. (Tr-354)

Any contamination that might have entered the lacerated wound would have manifested itself very quickly because skin over the tibia is thin. From the testimony thus far discussed, we have seen that the lacerations had healed cleanly by July 5, 1952, and that specimens taken from the wound itself on July 11, 1952, and viewed microscopically by the pathologist, were negative as far as showing any infectious bacteria. This proof negatives any claim that the wound became infected in Portland, Oregon, while the appellee was in the Physicians & Surgeons Hospital.

After the sliding bone graft and the plating of the fractured bone the incisional wound was slow to heal. Appellee apparently felt that he was not making the progress that he had hoped for and, being away from his home and family, elected to leave the U. S. Public Health Hospital in Seattle on August 13, 1952, against the advice of the hospital doctors and authorities. However, appellee left after stating in writing that he had knowledge that he still had an open wound in the lower left leg and that there was danger of the bone under the wound becoming infected. Appellee in said writing absolved the U. S. Public Health Service Hospital in Seattle and its staff from any responsibility in connection with his injuries, and from responsibility with regard to the outcome of those injuries. (Pltf's Exh. No. 3, page 70)

When appellee left the Seattle hospital his incisional wound was healing by granulation and there was a slight drainage from the wound. There was, however, no gross infection. By gross infection is meant infection that can be seen. (Dr. William R. King, Tr-320). Dr. King further testified that there was an open wound in this case and that there was serous drainage. Dr. Walker explained that whenever there is granulating tissue there will always be serous drainage, and that a granulating wound is healing by secondary process, that is, it is healing from the bottom up. (Tr-332)

Plaintiff returned to Portland and contacted his own doctor, Dr. Thorup, who called in Dr. Cherry as consultant. On August 24, 1952, appellee went to Providence Hospital, where his history was taken and he underwent surgery under general anaesthetic by Dr. Cherry, who performed a manipulation of appellee's fractured leg to straighten an angulation of the bone. Dr. Cherry offered this testimony as to his description of appellee's wound when he first saw him. The following statement is significant in this part of Dr. Cherry's testimony. Referring to some of the treatment rendered at Seattle, he said:

> ". . . They put the plate and screws and bone clamp across this fracture and then they nursed it along. The wound was slow to heal. It gaped a little for quite a while but finally it *did heal almost entirely* and that is the time when he came down to us." (Tr-248) (Emphasis added)

And again he stated:

> "It had a slight amount of drainage. . ." (Tr-204)

At this point, however, we run headlong into opposing testimony as given by plaintiff's expert witness, Dr. Cherry, pertaining to drainage. He says:

> "Drainage is due to bacteria, to a bacterial infection, which is present in a wound, essentially pus." (Tr-210)

Dr. Walker took serious issue on this point. He testified that Dr. Cherry wouldn't really know whether there was infection or not in the absence of a culture. He stated that pus can be sterile; and, "it doesn't have to have organisms in it to have pus." (Tr-337)

Then Dr. Cherry proceeded to testify as to his great concern about the condition of this wound. He described the condition of the wound as he first saw it many times in his testimony and his description each time varied somewhat. The following are some of his observations:

> "There was drainage present; there was a crusting on the wound; the skin was discolored and warmer than normal; its appearance was not normal. It looked critical, that the entire thing might break down. In answer to your question, the answer is, yes, there was infection present. It was not enough at that particular time to make him sick, but it was very unhealthy tissue and there was some infection present, and there was

enough that we were much concerned about it." (Tr-206)

"It just had the appearance that it probably would not hold up." (Tr-207)

"We were scared, for it was critical and we thought it might not go ahead and heal, which it subsequently did not do. . ." (Tr-211)

Dr. Cherry's testimony must have been based on his personal recollection rather than on records maintained in his office, or records at the Providence Hospital where the plaintiff was taken. Dr. Cherry was requested to produce his office records, and Plaintiff's Exhibit No. 12 represents what purports to be his office records. Plaintiff's Exhibit No. 6 is the Providence Hospital records on this case. Particular reference is here made to the personal history and physical examination record as made by Dr. S. R. Hevel, dated August 24, 1952, and a part of the Providence Hospital records. A part of the history pertaining to Mr. Morin is as follows:

". . . This forty-four year white male was last well June 10, 1952, when he fell from ladder at home sustaining compound fractures, left tibia and fibula, lower third. Treated for two days—then simple closure and manipulation reduction. Unsuccessful — plated—split skin—*healing at present.* Reduction still said to be inadequate. Also compression fracture L2—body cast for nine weeks—no symptoms now." (Emphasis added)

Under heading "Physical Examination", under Symbol NMO:

> "Long leg cast, left, incision over lower tibia granulating. Signed J. M. Thorup (Plaintiff's personal physician)".

Again "Progress Record", dated August 24, 1952:

> "Forty-four year white male compound fractures of left tibia and fibula *granulating*. Old open reduction incisional line. . ." (Emphasis added)

Dr. Cherry explained what was meant by granulating wound. He said that it is a wound not yet healed and that granulation is the process of attempting to heal. (Tr-210 and Tr-256)

Defendant's witness, Dr. Walker, explained that healing by granulation tissue is secondary healing; a granulating wound is a clean wound and is healing from the bottom up. It would certainly appear that if this wound was in the critical condition described by Dr. Cherry, and if there were actual infection present, these hospital records somewhere would make some reference to this condition. Must we assume therefore that Dr. Hevel and Dr. Thorup were remiss in their duty; that they neglected to record on the hospital records what the true facts were?

Dr. Cherry certainly made it abundantly clear that he wanted the trial judge to believe that this wound on the left tibia was in a very bad condition; that it was critical;

that it was infected; and the following quotation from the record should make it crystal clear what Dr. Cherry would have us believe:

> Q: "You said it was open when he came down from Seattle?
>
> A: "It was open, because pus was draining out of it; the bugs were going out, not in.
>
> Q: "Does that mean that was osteomyelitis simply because there was some drainage coming out?
>
> A: "No, I didn't say that.
>
> Q: "Was there osteomyelitis, doctor?
>
> A: "There was osteomyelitis, very definitely, and I had specimens taken at the time I took the plate out. He had soft tissue infection and possibly osteomyelitis before that." (Tr-251)

The last answer aforesaid is, of course, inaccurate in that the entire record otherwise refutes that Dr. Cherry ever did have any specimens taken when he took the plate out, which was in February, 1953, and in fact, it is testified to elsewhere in the case that it was practically a universal practice that doctors everywhere have specimens taken and that they are examined microscopically. It seems unbelivable that Dr. Cherry, an orthopedic specialist, would have violated such a rule. What Dr. Cherry actually did was to

turn over to the pathologist the Egger's plate and screws to be identified as such. See pathologist's report (Pltfs Exh. No. 6) also (Cherry Tr-258). It is not understood why Dr. Cherry, in giving the aforementioned testimony, said that he had specimens taken and that it definitely was osteomyelitis. This, of course, carried the implication that there was such a pathologist's finding, when in fact there was no such report or finding. We submit the last answer of Dr. Cherry, stating that the patient had soft tissue infection and possibly osteomyelitis before "that", referring to the time when he took the plate out on February 2, 1953. This answer was, that there was ". . . *possibly* osteomyelitis started in this leg." Appellant maintains that no one knows how or when the infection or osteomyelitis started. Any doctor who attempts to pinpoint the beginning of the trouble here or the cause of the infection that eventually resulted is certainly speculating as to the cause and source. Quoting again from Dr. Cherry's testimony when reference was made to the man's condition upon being brought down from Seattle, Dr. Cherry was asked:

> Q: "Are you able to say that there was an active infection in there?
>
> A: "There was infection.
>
> Q: "That was osteomyelitis?
>
> A: "I can't prove it as osteomyelitis at that time.

Q: "Then did you take the risk of manipulating these bones without knowing whether or not it was osteomyelitis?

A: "If there were osteomyelitis present, it would not hurt it to manipulate it to the degree that I did." (Tr-252)

It seems inconceivable that this leg was in the critical condition as testified to by Dr. Cherry, or that there was any infection such as he would have us believe. The other testimony in the case makes it incredible that Dr. Cherry, who undoubtedly is a good doctor, in the face of an active infection and possible osteomyelitis at that time according to his answer aforesaid, would take the risk of activating and spreading an infection by manipulating this bone. This procedure was not a minor thing, as is shown by the hospital record here. The Providence Hospital records (Pltfs Exh. No. 6) show that four days of hospital care and attention was thought necessary to restore his condition and enable his discharge on August 28, 1952. He was under a general anaesthetic at the time of this manipulation. Also to be considered is the fact that the fractured leg where the tibia was splintered was being protected by a plate and four screws and any pushing around of this nearly healed fractured bone would probably affect the plate as it was fixed to the bone and alter and modify or change in some way its fixation to the bone proper. With reference to this manipulation, Dr. Paul Walker, head of the U. S. Public

Health Service Hospital in Seattle, Washington, a member of the National Board of General Surgeons and apparently a very capable surgeon, had this to say about this manipulation:

> "One reason I would not have manipulated it is because if he already had an infection he was certainly asking for trouble by manipulating it under a general anaesthesia, and it must have been quite a manipulation, because apparently considerable force was used." (Tr-336)

If there actually was infection in the wound at that time, manipulation could have been the direct cause of it becoming activated. This is the direct testimony of Dr. Warren C. Hunter, the leading pathologist of Oregon (Tr-353), and of Dr. Richard F. Berg, orthopedist. (Tr-361)

It appears that Dr. Cherry was mistaken when he testified that at that time there was infection in this wound. His testimony is inconsistent in this respect. As previously pointed out, he testified that when plaintiff came down from Seattle, his wound was nearly healed. At a later point he said that there was a slight amount of drainage. That seems inconsistent with his other statements—that the "pus was draining out, and the bugs were going out, not in", and again, "There was infection. I can't prove it was ostemyelitis at that time."

Appellant states the fact to be that there was an open wound at the time and that there was some drainage, but

that it was not infectious. That position is supported, as aforesaid, by the records at the Providence Hospital where there is absolutely no reference whatsoever to any infection. Now Dr. Cherry testified *that he continued to see the plaintiff at regular intervals thereafter and that he checked him by having X-rays and changing of the cast as needed until the fracture was solid, and that he continued to observe the wound and that it actually gradually got worse until "we had to rehospitalize him for further treatment on January 24, 1953."* (Tr-207) (Emphasis added). It appears that the records will not support Dr. Cherry in this line of testimony. For a while, following plaintiff's arrival in Portland, there probably was some drainage. On September 10, 1952, when plaintiff went to the Providence Hospital as an outpatient for a change of his cast, there appears on the records a notation: "Dressing was changed through a window in the cast." Again on October 23, 1952, there is the notation "Beltman's gauze dressing applied, tenser bandage applied." (Plfs Exh. No. 6) It is probable this change of dressing was because of some drainage from the wound. If there were any further treatment rendered the plaintiff at either the Providence Hospital or in Dr. Cherry's office, one would expect to find some record of it. Dr. Cherry was critical of the records of the Physicians & Surgeons Hospital in Portland, where plaintiff was first confined. It was reasonable to expect him to be able to show from his own records what treatment he rendered. If there was infection

and progressive deterioration of the leg, his records should disclose it. Nowhere, as far as we can find, is there any reference to establish infection from the time that plaintiff first went under Dr. Cherry's care until January 24, 1953.

There is a very plausible explanation for the drainage continuing in this leg. If we will refer to Plaintiff's Exhibit No. 13, page 382 of Campbell's Operative Orthopedics, we will note this language:

> "In utilizing metallic internal fixation, one must be cognizant of its disadvantages; in the majority of cases, additional trauma will be created by exposure and stripping incident to the application of the fixation material. Regardless of how inert it may be, the metal must be considered a foreign material to the normal anatomic structures. *If sepsis ensues, draining sinuses will probably continue until the metal is removed. . .*" (Emphasis added)

One of Dr. Cherry's statements would tend to support this position. In referring to drainage, he testified:

> ". . . the plate and screws consist of foreign materials and tend to keep this going. . ." (Tr-208)

There was a great deal that Dr. Cherry could have filled in by testimony covering the period from August 24, 1952, to January 26, 1953, had he been so inclined. He stated that he continued to see this patient, but he did not tell how or why he referred Mr. Morin back to the U. S. Public Health Service, where commencing November 5, 1942 he

received treatment at the out-patient clinic on the second floor of the U. S. Courthouse in Portland, Oregon, Dr. Magid being the attending doctor. Dr. Magid's record is covered in Defendant's Exhibit No. 20. It is to be noted that Dr. Magid's testimony is clearly contrary to the testimony of Dr. Cherry as to there being an open wound during this period. (Tr-283 and Tr-286) Toward the end of Dr. Magid's treatment it is to be noted that plaintiff was up and about without any cast and with scarcely any pain. He was walking on his leg and putting his full weight on it. It is further significant that throughout Dr. Magid's notes there was no reference to any discharge or drainage from this wound. The Court will appreciate the fact that at the time these notes were made there was no suggestion of any pending lawsuit and hence considerable weight should be given to them. Dr. Magid was reporting the man's condition accurately as he saw it. Attention is invited to the notation on November 13, 1952: "X-ray shows that healing is not complete"; also to other entries calling attention to the swelling of his knee; the pain that the patient reported to him; and on November 26, 1952, he reported: "The skin is thin and atrophic looking—discoloration over interior part of tibia." It would not appear that Dr. Magid had any inclination to cover up the facts; if he had, why did he report these conditions as just noted? There is further testimony of the witness, Boris Osher, that there were no antibiotics given to Mr. Morin any time during this period.

(Tr-289). This is certainly significant, for if there were any infection and/or an open wound, antibiotics would have been a logical part of the treatment. It is further significant that the record shows that a full-duty certificate was given to plaintiff to return to work, which was done with the concurrence of Dr. Cherry. (Tr-277) Mr. Osher confirmed the statement of Dr. Magid that the wound was healed. (Tr-289).

As further evidence of the fact that this incisional wound was healed prior to December 1, 1952, there has been set forth herein as Appendix A, a reproduction of the first page of a four-page history and report of physical examination which was made of plaintiff on April 25, 1953, the date of his entry to the Veterans Hospital in Portland, Oregon. (Pltfs Exh. No. 10) This history contains the facts that the plaintiff himself gave to the person writing the record down. We would not expect to find anyone who would be more apt to have knowledge of the healing of the wound than plaintiff himself. The first sentence that is significant as shown is:

> ". . . The skin wound healed and the body cast was removed in two months. . ."

This apparently has reference to the time that he was in Seattle, and the skin wound no doubt refers to the lacerated areas in the front of his shin bone. Farther down in the history there is the notation:

". . . The incision did not heal until November, 1952. . ."

Undoubtedly at this time the plaintiff had no thought in his mind of any litigation and he was interested certainly in getting relief and getting his leg cured. Therefore, it is felt that this record must be correct—no one would know better than he as to whether or not the lacerations or the incisional wounds had in fact healed. If this statement by the plaintiff himself is true, then of course Dr. Cherry is mistaken in his testimony. It is admitted that none of the four pages of which Appendix A is the first page was signed by anyone at the Veterans Hospital. We have no knowledge as to who took this history. It was plaintiff's exhibit. It may be contended by appellee that it was taken by an intern, or by someone who could have misstated the facts. If that be the contention, then we would refer to the narrative summary as a part of the same exhibit (Pltfs Ex. No. 10), which report is next to the record referred to as Appendix A and there again will be found the same history to this extent:

"The incision for the open reduction did not heal until November, 1952, at which time the cast on the leg was removed."

The report is signed by Dr. Jack B. Watkins, M.D., apparently one of the doctors in attendance on this case. In the same report, signed by Dr. Watkins, there is this further significant statement:

"Because of some loose screws in the tibial plate, it was removed in February, 1953, by open method and since *that time the skin has not healed in the area of the incision.*" (Emphasis added)

The Public Health Service record indicates that with the approval of Dr. Cherry appellee on December 5, 1952, was okayed for light duty. Later and on December 22, 1952, again with Dr. Cherry's approval, the appellee was given a "fit for full duty" certificate. From that time until January 24, 1953, we are informed from the testimony of appellee that he worked full time, first on the dredge Wahkiakum and later as a watchman. We have no testimony or evidence as to any treatment or care being rendered to appellee by any doctor during this period, although from Dr. Cherry's own testimony he continued to see him regularly until he was ordered to the Providence Hospital on January 24, 1953. Dr. Cherry's personal office record does not indicate any interviews or treatment from November 24, 1952, to January 24, 1953. (Tr. 373)

Plaintiff's Exhibit No. 6, being the Providence Hospital record, shows that appellee went to the hospital on January 24, 1953, and two days later on January 26, 1953, Dr. Cherry made a ½ inch incision over the tibia when *a small amount of pus was removed* with flakes of bone. (See Providence Hospital Operative Record dated January 26, 1953.) Here again Dr. Cherry felt impelled to paint as bad a picture as possible despite his own signature to this hospital record.

In his testimony he argued that the amount was *not* small but considerable. (Tr-257 and Tr-258).

On February 2, 1953, Dr. Cherry performed an operation removing the Egger's plate and four screws. His operative report is brief and is as follows:

> "Incision was made lateral of the plate over the lower third of the tibia, carried down to the plate. Four screws and the plate removed. The bone was smoothed off. The wound was closed with interrupted silk sutures. Compression dressing of sheet wadding and tensor bandage were applied. Signed H. Cherry."

In describing the condition of this wound Dr. Cherry has emphasized that the pus extended down to and into the bone. It is to be noted that appellant's specialists indicated that they would under no circumstances operate on this man's leg if it was thus infected.

One of the dangerous things about this operation, it would seem, was that with this infected and draining wound, Dr. Cherry removed the plate and the screws, thereby creating holes in the bone where the screws had been and inviting the infection to go directly into the marrow of the bone.

The following part of Dr. Cherry's report is significant: "The wound was closed with interrupted silk sutures. . ." In other words, with this serious osteomyelitis infection he bottled up all the infection inbedded in the wound. This is not consistent with Dr. Cherry's earlier statement when,

in emphasizing the need for early treatment of a compound fracture to avoid infection, he said there was danger in closing a wound if unattended for 24 hours; (Tr-241) in other words he tightly closed an infected wound but would leave open a wound having a possibility of infection. Does this not create a doubt that there actually was osteomyelitis on February 2, 1953?

Subsequent to the removal of the plate from appellee's leg his condition apparently deteriorated and he was referred by Dr. Cherry to the Veterans Hospital and was treated by them as set forth in Plaintiff's Exhibit No. 10.

The task devolved upon the orthopedic specialist, Dr. Cherry, to develop causation by showing that the ultimate condition of Mr. Morin was due to the alleged inattention in the hospital in Portland, Oregon, during the first six to eight hours. Such testimony as Dr. Cherry did give, attributing the present condition of Mr. Morin and the additional operations, treatment and suffering that he underwent at the Veterans Hospital to the alleged inattention, was pure speculation. Dr. Cherry has in fact admitted that the osteomyelitis could have been caused by other intervening circumstances. In testifying concerning the treatment rendered in Seattle, Dr. Cherry stated:

> "The wound was closed within a matter of a very few hours after he got to Seattle. The fracture was opened one other time. Of course, I can't say that it could not possibly occur—the fracture was opened one

other time to graft it under sterile conditions. I cannot say of course it could not possibly occur." (Tr-251)

Again he testified in response to question:

Q: "For that reason it is not at all uncommon, regardless of the treatment that is given, for them to develop osteomyelitis?

A: "With the modern method, in good hands and with the giving of antibiotics, you seldom see it. You see it, yes, but not very often when they are in good hands and there is early treatment, in a clean wound like that."

It was incumbent upon appellee to show not only that there was negligent medical practice exercised in the care given Mr. Morin in Portland, Oregon, but also that because of that negligence, the wound became contaminated. He must then further prove that the said contamination remained in this wound continuously and was the proximate cause of the infection that eventually developed and which infection progressed into the bone, causing osteomyelitis.

Then appellee herein is bound by the testimony he adduced and the evidence contained in his exhibits duly admitted into evidence as follows:

1. The lacerated wounds of appellee healed by first intention in USPHS Hospital in Seattle by July 5, 1952. (Pltfs Exh. 3, p. 18a)

2. The infection resulting in osteomyelitis could have come through the bloodstream. (Tr. 250)

3. The infection resulting in osteomyelitis could have been caused by the surgery on June 12, 1952, in the USPHS Hospital in Seattle. (Tr. 251)

4. The infection resulting in osteomyelitis could have been caused by the sliding bone graft operation on July 11, 1952, in the USPHS Hospital in Seattle. (Tr. 251)

5. Appellee is also confronted with testimony of his own witness, Dr. Cherry, that the wound began progressively to deteriorate under his care, whereas it had been getting well under the care of the USPHS and was in fact practically healed when Dr. Cherry assumed charge of the case.

It will be seen as aforesaid that appellee, through his medical expert, admits that the infection to Mr. Morin and the resulting osteomyelitis could very well have been caused by other intervening causes. In this connection, there is a rule of law in the State of Oregon that when evidence leaves the case in such a situation that the jury must guess as to which of several possible causes occasioned the injury, such part of the case should be withdrawn from their consideration. In this connection see the case of *Lippold* vs. *Kidd,* 126 Ore. 160, 169, 269 P. 210.

> ". . . The evidence established that the defendant had no X-ray photographs made of the plaintiff's eye. The plaintiff's testimony was to the effect that the defendant failed to make an examination of the interior of his eye with the ophthalmoscope. The foregoing established prima facie case of negligence, but negli-

> gence alone is not sufficient. The plaintiff is required to go further and establish by a preponderance of the evidence that such negligence was the proximate cause of the injury for which he seeks redress in damages and prove all items of injury. And this court has on previous occasions enunciated the rule that when an alleged injury may have been due to one of several causes, any one of which may have been the sole proximate cause, there can be no recovery unless it is shown that as between the two or more causes in question, it was the negligence of the defendant which caused the injury: *Merrian* v. *Hamilton*, 64 Or. 476 (130 Pac. 406); *Engstrom* v. *Wise Dental Co.*, 97 Or. 634 (193 Pac. 187); *Spain* v. *O. W. R. & N. Co.*, 78 Or. 355 (153 Pac. 470, Ann. Cas. 1917E, 1104).

There can be no liability against the government in this case unless its doctors were guilty of some negligence during Mr. Morin's first hospitalization in Portland, Oregon, and which negligence was the proximate cause of the ultimate result to-wit: osteomyelitis. Proximate cause has been defined to be that which, in a natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury, and without which the result would not have occurred. There has been some extremely loose language used in this case on behalf of appellee tending to prove causation. We do not believe this testimony is substantial and worthy of belief.

Appellant contends that a medical expert's opinion as to the degree of care and skill that was exercised by ap-

pellee's doctors, may be based: (1) upon his personal knowledge of the operation or treatment in issue, obtained either by attendance during such operation or treatment, or from observation of the patient thereafter, or (2) entirely upon facts set forth in a hypothetical question. Appellee does not contend that his expert had any personal knowledge of the care and attention or operation performed upon appellee in the Physicians & Surgeons Hospital in Portland, and certainly, the examination of Mr. Morin by appellee's expert, which took place several months following the initial care, would be too remote to form a basis for appraising the degree of care and skill initially given to Mr. Morin. See *Hilgedorf v. Bertschinger,* 132 Or. 641, 285 P. 819.

With reference to expert testimony based upon a hypothetical question, the leading case of *Lehman v. Knott,* 100 Or. 59, p. 70, 187 P. 1109, lays down the rule that a hypothetical question is improper if it seeks the opinion of the witness on the merits of the case, and also states generally, the requirements as to the form of the hypothetical question. Judge Bean, on page 70, stated as follows:

> "As an expert is not allowed to draw inferences or conclusions of fact from the evidence, his opinion should be exact upon a hypothetical statement of fact. It is the privilege of counsel to assume any state of facts which there is any testimony tending to prove, and to have the opinion of the expert based on the facts assumed. But the testimony should tend to establish the

facts embraced in the question. If the hypothetical question is clearly exaggerated and unwarranted by any testimony in the case, an objection to it should be sustained: *Rodgers on Expert Testimony* (2 ed.), § 27. The form of the hypothetical question, whether it states facts, or puts facts hypothetically, or refers to the testimony of witnesses as being true, should be shaped so as to give the witness no occasion or opportunity to decide upon the evidence. Hypothetical questions are clearly improper if they directly seek the opinion of the witness on the merits of the case: *Rodgers on Expert Testimony* (2 ed.), § 28. In a malpractice case the question whether a physician has in a given case adopted the proper treatment is one in which the opinions of medical men may be received in evidence, and they may state whether in their opinion the treatment was proper or not, whether it was in conformity with the rules and practice of the profession: *Rodgers on Expert Testimony* (2 ed.), § 64; 22 C.J., p. 663, § 758; *Heath v. Glisan,* 3 Or. 64; *Hoener v. Koch,* 84 Ill. 408; *Taylor v. Kidd,* 72 Wash. 18 (129 Pac. 406). As the opinion evidence rule is intended to provide against the danger of invasion of the province of the jury, a court should, as far as possible, exclude the inference, conclusion, or judgment of a witness as to the ultimate fact in issue, even though the circumstances presented are such as might warrant a relaxation of the rule excluding opinions but for this circumstance. But the rule is not absolute, for it frequently occurs that the only possible or practicable method of making proof of the fact in issue is by means of opinion evidence; 22 C.J., p. 502, § 597; *Jones on Evidence* (2 ed.), p. 465, § 372."

In *Henderson v. Union Pacific RR Co.,* 189 Or. 145, p. 166, 219 P. (2d) 170, the Supreme Court of Oregon stated:

> "There is considerable authority for the rule that a hypothetical question must include all the essential, undisputed facts shown by the evidence."

And again:

> "It is the rule in this state, as elsewhere, that 'an expert, though thoroughly qualified as a witness, cannot be permitted to give an opinion upon facts known to him, and not communicated to the jury'; that 'no allegation can be proved by the ipse dixit opinion of any expert unless the fact or phenomena upon which he bases his opinion are disclosed either by his own testimony or that of other witnesses'. (citing cases)."

In this case, although there had been much previous testimony, particularly by Dr. Schneider, as to what he did by way of emergency treatment to Mr. Morin, these facts were not incorporated in a hypothetical question propounded to Dr. Cherry. When he was asked (Tr-240) whether or not Morin's wound had been properly treated, Dr. Cherry answered: "I would say no." This answer was predicated upon the hospital statement from Plaintiff's Exhibit No. 1, (Tr-240). Since it was not predicated on the entire treatment as testified to by plaintiff's witness, Dr. Schneider, this testimony of Dr. Cherry should not be considered as substantial.

Counsel for appellee (Tr-242) and (Tr-243), asked a further hypothetical question which was objected to because the facts were inaccurate and the question did not embrace the full treatment which was rendered to Mr. Morin, the objection embracing some of the facts that were omitted from the hypothetical question. The court overruled the objection and permitted the witness to answer. The answer by the witness (Tr-244) clearly invaded the province of the court, in that the witness admits that he had given considerable thought to the facts brought out, by his own investigation, and his answer clearly was a conclusion and a judgment of an ultimate fact in issue in this case. He states, in part:

> ". . . everybody knows . . . that I have very thoroughly studied all the charts; I have read and studied the reports of the physician; I have talked to the patient. I have deliberated this whole question in my mind for a matter of weeks. . . . I still have to say that the treatment was not correct; it was not what he should have obtained; . . ."
>
> "The answer to the hypothetical question as put is that in my opinion, under these circumstances, this patient did not get good care in his initial treatment."

This testimony is not substantial. It is not predicated on the entire undisputed facts. *Lehman* vs. *Knott,* Supra.

Again (Tr-246), counsel's question to Dr. Cherry:

> "Dr., under the circumstances under which man (sic) was suffering, what would you say would be

> the result of the failure to treat this man within six to eight hours?"

calls for an answer based on a false premise because Dr. Schneider, appellee's witness, testified that Mr. Morin was treated. Are we justified in reading into this question, the implication that "failure to treat", means "failure to adequately treat"? The question, being based on a false premise, the answer could not be considered substantial evidence. To the same effect is Dr. Cherry's statement as follows:

> "In observing this case, the records I have seen, I think the number of months of treatment and the number of operations and days of hospitalization and pain —I think, it was very greatly lengthened." (Tr-246)

This answer is again based on the incomplete hospital records and not on the record evidence of appellee. As we have repeatedly set forth, the records were incomplete and did not incorporate what was actually done by Dr. Schneider. Again, in connection with this answer, the court is left to speculate as to what Dr. Cherry actually meant when he twice used the words "I think".

Reference is further made to counsel's question to Dr. Cherry (Tr-249):

> "Was the treatment rendered responsible for the present condition of Mr. Morin?
>
> A: "Yes."

Here, again, the court must speculate as to what Dr. Cherry had in mind when reference was made to "the treatment rendered". As has been repeatedly covered aforesaid, Dr. Cherry has never acknowledged that there was anything done to this wound except as shown on the incomplete hospital report. (Tr-240) See Dr. Cherry's statement relative thereto as follows:

> "From this report, this fracture was not treated. I mean the report does not say that it was treated. All the report says is that a compression dressing was put on." (Tr-240)

Again, Dr. Cherry stated: ". . . that the treatment was not correct; . . ." and, ". . . this patient did not get good care in his initial treatment. . ." (Tr-245)

What does this testimony mean? Does it mean that the treatment was negligent? In *Lehman* v. *Knott,* supra,—

> "The distinction between improper treatment and negligent treatment is not as broad as it is vital. Improper treatment by a surgeon might be due to an error in judgment of a skilled surgeon, honestly and carefully exercised, and not constitute negligent treatment.— (citing cases)"

The Fifth Circuit in deciding the case of *Sanders* vs. *Leech,* 158 F. 2nd, 486, 487 lays down a reasonable rule:

"Under Rule 52a Federal Rules of Civil Procedure, it is not for the appellant court to substitute its judgment on disputed issues of fact for that of the trial court where there is substantial credible evidence to support the finding. It may reverse though, under the rule (1) where the findings are without substantial evidence to support them; (2) where the court misapprehended the effect of the evidence; and (3), if, though there is evidence which if credible would be substantial, the force and effect of the testimony considered as a whole convinces that the finding is so against the great preponderance of the credible testimony that it does not reflect or represent the truth and right of the cause."

See also *U. S.* vs. *U. S. Gypsum Co.,* supra; *Lassiter* vs. *Guy F. Atkinson Co.* (CA 9), 176 F. 2d 984.

It is submitted that there is no substantial evidence in this case to support the appellee herein, the testimony overwhelmingly supports the appellant and we believe the court misapprehended the effect of the evidence.

ARGUMENT IN SUPPORT OF POINT FOUR OF ITS ASSIGNMENT OF ERROR

The Court found that defendant herein was negligent and careless in failing to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon, and like communities in the treatment of comminuted compound fractures of the left tibia. It is contended that

there is no substantial evidence in this case to warrant this finding.

There is no evidence that the doctors charged with the early care of appellee abdicated or shirked their responsibilities. There is ample proof that they did exercise their professional judgment as to what treatment and care Mr. Morin should initially be given. Can it be said from a careful examination of the record that what those doctors did and the decisions they made were improper? If it was improper, was it not an error of judgment in retrospect and not negligence?

As to appellant's doctors not using that degree of care and skill in treatment of Mr. Morin which is ordinarily used by the average member of the medical profession in this community, there is a preponderance of the testimony herein of medical witnesses representative of a respectable segment of medical opinion of this community who testified that the treatment given to Mr. Morin, due to his serious condition, called for the exercise of medical discretion by appellant's doctors; that there was substantial evidence by these professional witnesses that the treatment given as determined upon in the judgment of appellant's doctors was such as to refute appellee's one contrary witness, and still physician of appellee, that the medical agents of the appellant were negligent in the exercise of discretion.

The *Malila* v. *Meacham* case, 187 Or. 330 at 354, 211 P. (2d) 747, cited as authority for the fact that a physician is

no insurer or warrantor of cures. In that case the Supreme Court of Oregon said:

"It is well settled that a physician or dentist is not a warrantor of cures, that the doctrine of Res ipsa loquitur does not apply in malpractice cases, and that, if a regular licensed physician or dentist with reasonable diligence employs the skill of which he is possessed in treating a surgical case, he is not liable for an error in judgment. *Moulton* v. *Huckleberry,* 150 Or. 538, 46 P. (2d) 589; *King* v. *Ditto,* 142 Or. 207, 19 P. (2d) 1100; *Rayburn* v. *Day,* supra, 126 Or. 150; *Emerson* v. *Lumbermen's Hospital Assn.,* supra, 100 Or. 481; *Lehman* v. *Knott,* supra, 100 Or. 71; *Hills* v. *Shaw,* 69 Or. 460 (1869). In *Moulton* v. *Huckleberry,* supra, the court explained the limitations of the rule as follows (150 Or. 546):

'It has sometimes been broadly held that a physician or surgeon is not liable for an honest error or mistake in judgment. Nevertheless a limitation of this broad rule is recognized in cases that exempt from liability for errors of judgment only where there is a reasonable doubt as to the nature of the physical condition involved or as to the proper course to be followed, or where good judgments may differ. Also another limitation of the broad rule stated is found in cases that hold that a qualified physician is not liable for an error of judgment if he applies ordinary and reasonable skill and care: 48 C.J. 1127, § 114.'

"In other words, to avoid liability the judgment of the physician or surgeon must be founded in his intelligence, skill, knowledge and care. *King* v. *Ditto,* supra, 142 Or. 217; *Rayburn* v. *Day,* supra, 142 Or. 151. . ."

Dr. Richard F. Berg, an orthopedic specialist in the city of Portland, Oregon, in commenting upon the care as given by the attending doctor in the initial phases of this case, stated:

> "Well, a qualified man, I would say, should have a little better insight into it than someone who had not seen the circumstances. As I stated, every case presents a different situation, and it is hard for me to sit here and put the finger on someone whom I did not watch do the work. Based on general experience, as I say, I see nothing to be criticized in that treatment." (Tr-360)

Again quoting from Dr. Richard F. Berg's report set forth on Transcript page 393:

> "It is my feeling that this man's treatment has followed the pattern which is quite common in severe injuries such as his, and that unfortunately he developed some osteomyelitis which is likewise a fairly common incident in traumatic compound fractures." (Tr-393)

It must be borne in mind that when Mr. Morin came to the Physicians & Surgeons Hospital and was admitted to the emergency surgery the history there given to Dr. Schneider was that he had fallen 20 feet and had lit on the base of his spine. With that history there can be little doubt that concern about Mr. Morin was warranted. As Dr. Schneider said, he was afraid to examine him more closely because he complained so bitterly of his back, and

again he said that he was afraid that the fracture of the back might sever his spinal cord and cause paralysis. In the face of that history, it seems that Dr. Cherry's bitter criticism of appellant's doctors at this late date comes in poor grace. It is submitted that the court was in error in determining that the care and skill as exercised by appellant's doctors was not of the degree as would be normally given by doctors in like communities.

ARGUMENT IN SUPPORT OF POINT SIX OF ITS ASSIGNMENT OF ERRORS

The discussions and arguments heretofore set out relative to appellant's statement of Points One thru Five are herein adopted in toto in support of appellant's Point Six. No additional argument is therefore deemed necessary.

ARGUMENT IN SUPPORT OF POINT SEVEN

The court's award of $45,000.00 general damages in addition to the special damages awarded, which included alleged loss of wages and medical expenses to the time of trial, appears so excessive as to be "clearly erroneous", if the court should sustain the finding of negligence. The award of damages is appropriate for the appellate court to review "when the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake

has been committed." (*U. S. v. U. S. Gypsum Co.,* 333 U. S. 364, 395; 68 SC 525, 542; 92 L. ed. 746; *U. S. v. Guyer,* 218 F. 2d 266 (CA 4, 1954). In the case of *U. S. v. Guyer,* supra, the court stated:

> "When convinced that a finding as to damages is clearly erroneous because in excess of any amount justified by the evidence, it is our duty to make a finding ourselves on the evidence in the record if this can be reasonably done."

Plaintiff's evidence claims occupational experience as a hardrock miner and a present occupation as 3rd Mate on the dredge Wahkiakum, the latter being a civil service job in which the plaintiff claimed about $450.00 per month take-home pay, with a prospective retirement from the civil service job after 12 more years. There is no showing that he will be incapacitated in his occupation, and, in fact, during the time between his injury and the trial, he had intermittently worked and at the time of trial was employed at full wage rate.

The plaintiff suffered grievous and serious injuries in his accidental fall, for which the government had no responsibility. The pain and suffering caused by that fall and the resulting physical impairment could be anticipated to be great and the recovery time-consuming with the most ideal treatment. It is unquestioned that at some state in the plaintiff's extensive treatment, osteomyelitis developed and additional surgical procedures were undergone which

resulted in inactivity, discomfort and disfigurement. The evidence of prognosis in the case from Dr. Cherry that osteomyelitis may recur is, at best, speculative. The testimony of Dr. Berg indicated that if a sequestrum were removed by surgery, he would consider the plaintiff's disability greatly lessened. (Tr-393) Remaining for primary consideration is the amount of reasonable compensation to be awarded. Assuming *arguendo* that negligent treatment was afforded the plaintiff by agents of the defendant and that such negligent treatment caused the osteomyelitis, it is to be determined how many of the operative procedures resulted from the osteomyelitis and what compensation the plaintiff should be entitled to for undergoing such operations and any disfigurement caused by any such procedures found to be attributable to the negligence of the defendant's agents, if any.

$45,000.00 seems excessive as compensation for disfigurement of a portion of the plaintiff's anatomy which, in the normal course of his activities, is clothed. It likewise seems excessive coupled therewith for the discomfort attendant upon his hospitalization and convalescence for the period beyond which he could have normally expected pain, suffering and treatment under the most ideal of circumstances. It is asserted that the plaintiff was an active man, fond of sports and physical activities in the pursuit of which he is now restricted. The evidence is that the plaintiff, at the time of the judgment, was 45 years of age, and many

of the activities for which he claimed fondness, in collaboration with his children, could not be expected normally to long continue. His employability in the civil service job appeared, from the evidence, unhampered.

Comparable cases involving actions for medical negligence in Oregon indicate the judgment would be so excessive as to be clearly erroneous. See *Olson v. McAtee,* 181 Or. 503, 182 P. 2d 972. See also, cases in the neighboring state of California: *McCullough v. Langer,* 73 P. 2d 649, 23 Cal. App. 2d 510, which found $25,000.00 as reduced from $50,000.00 not excessive for burning of crushed thigh from infra-red rays, under evidence that the injury was permanent, involved great pain, impaired plaintiff's earning ability and made necessary repeated skin graftings. See, also, *Kershaw v. Tilbury,* 8 P. 2d 109, 214 Ca. 679, that $30,000.00 award for unskillful treatment of osteomyelitis of leg of a 9-year old girl was excessive by $10,00.00. And in the neighboring state of Washington, see *Olson v. Weitz,* 221 P. 2d 537, which was a malpractice action. Therein the court held that a verdict of $15,000.00 for injuries consisting of necessity for open reduction and bone graft, pain, suffering and permanent injury resulting from malpractice by physician was excessive, but an award of $9,000.00 was sustained after the trial court had ordered $6,000.00 of verdict remitted as a condition to denial of a new trial. That such considerations are appropriate for consideration of the appellate court is held in *U. S. v. Guyer,*

supra. See also *Taylor vs. Kidd,* a Washington case reported in 72 Wash. 18, 129 Pac. 406, wherein the plaintiff sued for alleged malpractice of the defendant in setting a broken arm. Judgment was rendered in favor of plaintiff, which was on appeal affirmed conditionally. The court said:

> "Finally, it is said that the verdict is excessive. With this contention we are inclined to agree. The size of the verdict would indicate that the jury felt inclined to visit the entire loss suffered by the appellant upon the doctor, whereas he was only responsible for the injury and suffering caused by his own acts, not those caused by the original injury with which he had nothing to do."

ARGUMENT IN SUPPORT OF POINT EIGHT OF ITS ASSIGNMENT OF ERRORS

The court found "that plaintiff will be required to undergo further operations. . ." Appellee's doctor stated (Tr-249):

> ". . . he has osteomyelitis which may recur—it has a tendency to recur. . ."

Dr. Berg said in his written statement (Tr-393):

> "At the present time, I think the persistence of the drainage is probably due to the small sequestrum which is visible in the lower portion of his wound and which will probably be extruded spontaneously if it is not curetted out before that time. . ."

It is not believed there is any testimony supporting this finding and therefore it was error for the court to so hold.

CONCLUSION

For the foregoing reasons, the judgment appealed from should be reversed and the complaint herein dismissed.

Respectfully submitted,

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Appendix A

Standard Form 504
Rev. Feb. 1964
Prescribed
By Bureau of the Budget
Circular A-43

[illegible] 87278 1-C

CLINICAL RECORD | HISTORY—PART I

NATURE AND DURATION OF [illegible] of [illegible]

Drainage from old fracture
sub left tibia

[illegible]

44 yr old male was in good health until June 1962 when he fell off a ladder and fractured the left lower tibia & fibula (compound). There was also a comminution fracture of L-2. He was treated c long leg cast and body cast. The skin wound healed and the body cast was removed in 2 mos and the leg cast was removed in Dec 1962. In July the tibia had spontaneously grafted and a metal plate applied. The incision did not heal until Nov 1962. Because of "poor alignment" the plate was removed in February 1963. Since that time the skin has not healed in the area of incision.

[illegible]

[illegible] | [illegible] | [illegible]

[illegible]